CLINICAL MEDICINE

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AUTHORITATIVE INDEPENDENT PRACTICAL

JANUARY
1949
VOLUME 56
NO. 1

PUZZLE: Find the complex equipment

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No complicated tubes, valves, oxygen tanks or air machines are required with the Aerohalor. The patient may use this inexpensive little device for oral or nasal inhalation at home, at work or in your office. It consists of a discharge chamber plus interchangeable mouthpiece and nosepiece. It is used with disposable Abbott Sifter Cartridges, each containing 100,000 units of finely powdered crystalline penicillin G sodium. For oral inhalation, the patient simply attaches the mouthpiece to the discharge chamber, inserts a cartridge of penicillin and "smokes" it like a pipe—by inhaling, removing, exhaling. Nasal use is similar except that the nosepiece is used. This treatment is indicated for infections of the respiratory tract produced by organisms susceptible to penicillin. It is contraindicated in infections not susceptible to penicillin and for patients allergic to the drug. No serious reactions have been reported.

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CLINICAL MEDICINE

JANUARY, 1949

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Editorial

THE PRIVATE OFFICE AS A HEALTH CENTER

IF THE general practitioner is unwilling or unable to do a health maintenance examination, the patient will perforce go to a clinic which has announced such a service. There has been much publicity lately on the importance of general physical examinations in the detection of cancer and in the maintenance of health. When a New York tabloid featured the opening of the Strang Clinic in New York, a flood of letters and calls poured in. Many of these applicants were willing and able to pay their private doctors for this kind of service. How many of their doctors were willing and able to render this service? The cry that the operation of such a clinic, (whether designated a cancer prevention or a health maintenance agency) is a blow to individualized medicine, is constantly heard. It is fair to ask the complaining doctors if they are prepared to give their patients an equivalent service.

Patients have learned that a good physical examination including the history (and the drawing of specimens for blood count, urine analysis, blood serology) will take at least forty-five minutes. They will not be satisfied with anything more cursory. The doctor who is not prepared to devote the time and attention which this requires should send the patient to a colleague who is. If he fails to do either, let him not be surprised if the patient goes to a publicized health maintenance or cancer prevention clinic and gets a work-up at a reduced fee.

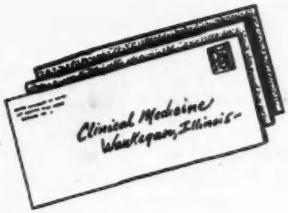
Follow-up is important, and doctors need no longer be deterred by fear that the patient will think he is trying to make an unnecessary fee. If, for example, a small mass is found, and biopsy does not seem indicated, a follow-up visit a few weeks later to see if the mass has grown, is sensible and the patient knows it is.

The demands for group medicine, for more clinics, for new health centers and the like is growing rapidly. A stand at this point, by offering complete diagnostic service, is the family doctor's chance to retain medical practice in its individualistic framework. It is, perhaps, his last chance.—*Jour. of The Medical Society of New Jersey.*

Measles and Sydenham

Thomas Sydenham (1624-1689), the "English Hippocrates," was a close friend of Robert Boyle and John Locke, and one of the great clinicians in the London of his day. He has earned a permanent place in medical history by his meticulous clinical studies, of which those on gout, chorea, hysteria, venereal disease and especially the acute infectious fevers are now the best known. His brilliant "Medical Observations Concerning the History and Cure of Acute Diseases," (in Latin), published in 1676, described and classified the acute febrile diseases seen in his practice between 1661 and 1675. The following slightly condensed extract from the chapter entitled "*Of the* Measles *in the Year* 1670" is taken from John Pechey's translation, Eleventh Edition, published in 1740:

"These *Measles* began very early, as they were wont to do, *viz.* at the beginning of *January* 1670, and increasing daily, came to their height in *March;* afterwards they gradually decreased, and were quite extinguished in the following *July* . . . This disease chiefly invaded infants, and all those that were together in the same house. It began with shaking and shivering, and with an inequality of heat and cold, which mutually expelled each other after the first day. The second day is ended in a perfect *fever,* with violent sickness, thirst, and want of appetite; the tongue was white, but not dry; there was a small cough, with a heaviness of the head and eyes, accompanied with a continual drowsiness, and for the most part a humour distilled from the eyes and nose . . . This disease shows itself most commonly in the face, after the manner of little swellings in the skin, yet in the breasts rather red broad spots rather than swellings are perceived . . . The eye-lids swell a little before they come out; he vomits but is oftener troubled with a looseness, and the stools are greenish . . . The symptoms increase for the most part till the fourth day, and then generally (tho' sometimes they are deferred to the fifth day) little red spots, like flea-bites, begin to come out about the forehead and other parts of the face, and being increased in number and bigness, branch into one another; . . . their protuberances may be perceived by a gentle touch, tho' they can scarce be seen. These spots spread themselves by degrees from the face, to the breast, belly, thighs and legs; but they affect the trunk and members with redness only, without any sensible inequality of the skin. The symptoms of the measles do not abate by the eruption, as in the small-pox; yet I never perceived the vomiting afterwards. But the *cough* and *fever* [may] increase, with the difficulty of breathing, weakness of the eyes, and the defluxion on them, with continued drowsiness, and want of appetite, as before . . . About the eighth day the spots in the face vanish, and are scarce perceived in the rest of the body, but on the ninth day they quite disappear. The face and members, and sometimes the whole body seem as it were to be sprinkled all over with bran, *viz.* Particles of broken skin . . . fall from the body like scales. And, as we said, the *measles* most commonly disappear on the eighth day . . . [Sometimes] the *fever* and difficulty of breathing are increased at that time, and the *cough* is more troublesome; so that the sick can neither sleep night nor day. Children are chiefly subject to this ill symptom."—I. J. WOLMAN, M.D.



Original Articles

An Easy Exposure for Biliary Surgery

By M. Cole-Rous, F.R.C.S., England
Professor of Surgery, University of Cape Town, South Africa

THE technical difficulties of surgical procedures on the biliary tract are well recognized wherever surgery is practiced. Any method which claims to facilitate this work and reduce hazards should be thoroughly tested on the operating table.

If the method to be described is practised a few times so that the operator may adapt himself to the slight variation from his normal operative environment, he will find an ease of access to the biliary tract which is as surprising as it is gratifying and which has to be seen and experienced to be believed.

There are probably not many surgeons who would happily embark upon a cholecystectomy knowing that the long curved clamps of the Moynihan type were not available, these being the clamps on which the surgeon relies for clamping off the cystic duct and artery. It will be remembered that when these long clamps grip the structures for which they were designed, but little of their handles can be seen projecting above the level of the wound. With a little experience of the new method the surgeon will find that straight 5½ inch forceps will be all he needs to deal adequately and easily with the cystic duct and artery. This holds good even when the patient is unusually fat. A curved clamp will be still more convenient. In a medium-sized patient it will be found that a pair of forceps clamping the cystic duct at its junction with the common bile ducts will have half its length projecting above the level of the skin wound.

Fig. 1. Demonstrating the position for biliary surgery. Note the large sand bag extending in from the top of the shoulder to the lower rib margin. *During the operation the left arm is usually at the side with the hand under the buttock.* The head of the table is a little higher than the foot.

The trick of achieving this easy exposure is very simple. It consists of placing a sand bag under the right posterior part of the thorax. The sand bag should extend from the top of the shoulder to the lower border of the thoracic cage and must be large enough to rotate

the front surface of the thorax through 25-30 degrees out of the horizontal and towards the left.

If a patient were placed so as to lie in the true lateral position the thorax would then be rotated through 90 degrees from the horizontal. In short: the upper half of the body is rotated towards the left. A slight additional advantage, which is not essential will be gained if the operating table is kept tilted so that the head is higher than the foot, the slope being 10-15 degrees.

The surgeon stands on the left-hand side of the patient. The incision of choice is a right paramedian which splits off the medial quarter or half inch of the rectus abdominis muscle as described by Sir Hugh Devine. Any anesthetic giving the adequate relaxation necessary for most major intra-abdominal operations is suitable.

Because of the patient's position and muscular relaxation, the abdominal viscera tend to fall to the left and downwards in the abdominal cavity. It is usually an advantage to clamp and divide the falciform ligament. A sponge forceps grips the fundus of the gall bladder and the usual abdominal packs are then placed below the gall bladder and to the left. A little gentle retraction will easily keep the viscera downwards and to the left, and out of the field of operation.

It will now be found that the duodenum and the head of the pancreas have moved on to the front of the vertebral column. The common bile duct is now almost in the mid-line and is much more superficial than usual. Its direction is now downwards and very obliquely to the left. The distance between the common bile duct and the incised peritoneum of the anterior abdominal wall will naturally vary with the size of the patient. In a small thin woman it may be half an inch and in a large fat woman of enormous proportion it may be three inches. If this very

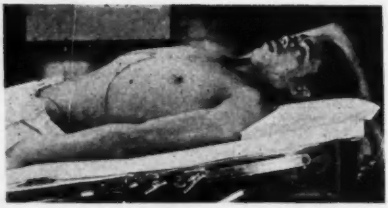


Fig. 2. The rotation of the thorax is clearly shown. The surgeon stands on this side.

superficial relationship is not borne clearly in mind the surgeon may inadvertently injure the common bile duct, or the structures closely related to it, in the gastro-hepatic omentum.

In this position it is easy to pass a pair of forceps past the right side of the common bile duct and a little above the duodenum. By displacing the bile duct a little to the left, it will be found that the forceps slips through the foramen of Winslow and into the lessor sac and passes to the left of the vertebral column.

The operator may now perform whatever procedure is indicated on the gall bladder or the bile ducts.

The author and his assistants have now performed over 100 operations by this method. The average operating time has been materially reduced. The anesthetists who have given the anesthetics are well satisfied. Other anesthetists, who have had no practical experience with the method, have raised objections on theoretical grounds suggesting that the position would reduce the patient's vital capacity. We have found nothing to support this contention.

A number of surgeons in different parts of the country who have mastered the knack of this position say that for them it has taken the sting out of gall bladder surgery. The general impression is that the use of this position has made life more easy for the surgeon and the anesthetist and more certain for the patient.

Clinicopathologic Conference (17)

A 5 year old boy entered the hospital because of hemoptysis of 5 days duration.

Present Illness: He had been well until two months previously when, while on a summer vacation, he had developed cough, fever and chest pain. He was treated for "pneumonia and empyema" with penicillin and sulfadiazine for one month with symptomatic recovery. Two weeks later his cough had recurred and had become productive of blood-streaked sputum. Later there had been several episodes of frank hemoptysis.

Physical Examination: An apathetic child with temperature of 100.0° F. There was dullness to percussion and diminished breath sounds over the right lung base. There was a mild leukocytosis. Tuberculin skin test was negative. Culture of the sputum contained coagulase positive Staphylococcus aureus. X-rays of the chest supported the clinical findings.

Course in Hospital: Despite penicillin inhalations, cough and low-grade fever persisted. Bronchoscopy and lipiodol bronchograms demonstrated bronchiectatic dilatations in the lower right bronchus. Bronchoscopy was followed by hemorrhage sufficient to require several blood transfusions. Penicillin inhalations were continued until patient's discharge. (See Fig. 1.)

Course at Home: Patient led a normally active life for nine months. He suffered from periodic troublesome cough and relatively mild upper respiratory infections produced an exaggerated febrile response. His breath was occasionally foul. There was no dyspnea, cyanosis, or hemoptysis. X-rays of the chest remained unchanged and patient failed to gain weight.

2nd. Hospital Entry: Temperature reached 100.5° F. daily. Findings at the right lung base were unchanged as were chest x-rays. Laboratory findings were unremarkable.

(1) What is the diagnosis?

(2) What therapy or further diagnostic procedures are indicated?

(3) What is the prognosis?

(Answer on page 7)

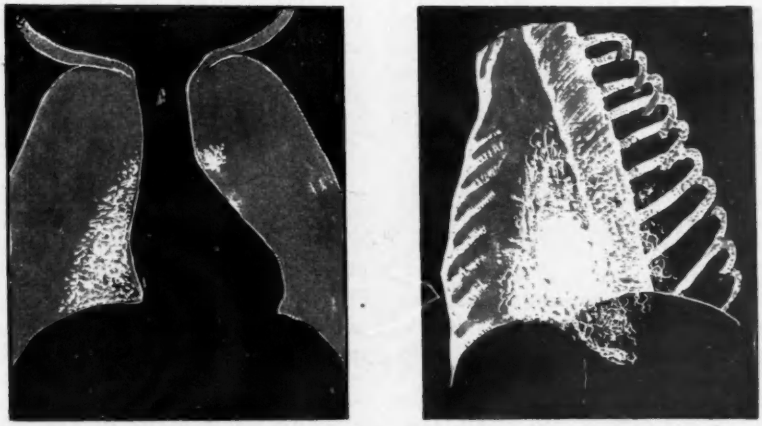


Fig. 1. X-ray Findings.

Sex - The Doctor's Dilemma

By A. K. DUNCAN, M.D., *Douglas, Arizona*

UNTIL recently it was accepted as normal that a lag of twenty years elapsed before knowledge (proven facts) were accepted and applied by or to the population as a whole. This really implies a new generation, as it is still true that when the facts meet old beliefs, customs, or habits they have a rather tough time being accepted. How much easier it is to drift along with the old beliefs, to cling to the old habits rather than to change. To the younger generation, this new knowledge appears as a fact or belief and so causes no mental upheaval. Not too long ago men were condemned to death for saying that the world was round, a fact which is common knowledge of every school child today.

Physicians have known for years the physical effects of emotional disturbances on the mechanism of the body, but in spite of scientific training have been slow in applying this knowledge in general practice. Why? Because doctors, too, are people. They, too, have beliefs, habits, hopes and fears like other people and are subject to taboos. Possibly even more so, as they feel they have more to lose, if a whispering campaign should damage their standing in the community.

The above applies very directly to the question of sex today. Dr. Walter Alvarez says that doctors are prudish[1]. I agree that many are, but from talking to many doctors as well as from personal communications, I would put fear as a more important factor in delaying the application of present day medical knowledge to the many cases in which sexual maladjustments are the basis of the physical complaints. Doctors in private practice seem to fear that if they show any interest in the sexual life or habits of female patients that they may be looked upon as psychopathic cases themselves or regarded as wolves in medical jackets, if not sheep's clothing. This is particularly true of the younger doctors and yet they are the ones who, especially since the recent war, appreciate the importance of psychosomatic disturbances.

Faced with this dilemma what does the doctor do? Too many say, "Why should I stick my neck out and risk losing practice?" "Let George do it." Others, without sufficient knowledge, attempt to approach the subject but blush, stammer and are visibly embarrassed, so that both the doctor and the patient are acutely uncomfortable. A few make a real study of the subject and so have the knowledge and ability to get a real history, as simply and rationally as they would about any other dysfunction. A short tactful explanation as to why this information is important for diagnosis and treatment sets the patient at rest and she quickly realizes that the doctor knows far more about this subject than she does so has no personal curiosity about her, any more than he has about her menstrual history, or bowel function, or any other of her physiological functions. The answer is, as it is to many other problems more knowledge and more training, first of the doctors and then of the public. Training the public is like training a dog,—first you must know more than the dog.

If half of the doctors today started applying what they already know, questions about sexual disturbances would quickly be accepted as routine by patients and would arouse no suspicions on their part. The subject should never

be approached furtively or as if it were something to be ashamed of, but as factually as a history concerning a gall bladder disturbance. This is already true of doctors who have earned a reputation for ability to treat such cases, and patients come to him prepared to discuss their troubles openly and intelligently. In fact I have noticed in the past few years a growing demand for information by patients as a result of many articles in lay magazines, and they expect the physician to know the answers. It begins to look as if physicians instead of taking their proper places as leaders of medical knowledge in their communities will be forced by patients to wake up and accept sexual disturbances as rationally as they now accept disturbances of any other physiological function.

As I have said before[2], we as physicians have no right to shirk our responsibilities in this matter but must acquire and apply the knowledge necessary to handle questions involving sexual dysfunctions. Since psychic disturbances may cause symptoms in every part of the body, this knowledge is essential to every physician regardless of whether he is engaged in general practice or in any of the specialties. We cannot honestly claim scientific status or independence if application of medical science is allowed to be shackled by ignorance, prejudice or taboos.

A. K. DUNCAN, M.D.
834 Ninth street.

REFERENCES

[1]Walter C. Alvarez, M.D. Clinical Medicine —Vol. 54 No. 5. pp. 158-59 May, 1947.
[2]Duncan, A. K. M.D. Arizona Medicine—Vol. 4—No. 4. pp. 32-36. July, 1947.

When you're arguing with a fool, make certain that he isn't similarly occupied

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Answer to Clinicopathologic Conference (No. 17)

See Page 4

Differential Diagnosis:

(1) Bronchiectasis, secondary to (a) Interstitial pneumonia, or (b) Bronchial obstruction with atelectasis and peribronchial fibrosis. (c) Rule out foreign body.

(2) Bronchial tumor or hemangioma.

(3) Tuberculosis (ruled out by negative skin test).

Procedures Indicated:

(1) *Bronchoscopy must be repeated to rule out foreign body despite history of previously performed negative bronchoscopy.*

(2) Consider lobectomy if bronchoscopy is again negative.

Results of Bronchoscopy:

The head of a fox-grass, measuring 2" x ¼", was readily removed from the right main bronchus.

Subsequent Course:

One year later the patient was asymptomatic. His chest was normal to physical examination and to x-ray.

Prognosis:

In bronchiectasis in children, symptoms subside once bronchial continuity has been re-established and despite the persistence of bronchial dilatation. *Failure of improvement to occur strongly suggests that a foreign body, or a pulmonary lesion, is present.*

Problems in Practice

(CONSULTATION SERVICE)

Treatment of Congestive Failure

Question:

What is a simple treatment for congestive heart failure? How can one tell when a patient is doing as well as he should? It sometimes seems to me that patients improve slowly to a certain point, then relapse and there doesn't seem to be any definite way of telling how the patient is responding to treatment.—M.D., Chicago, Ill.

Answer:

The treatment of congestive heart failure is often made too complicated as has been shown by Burch of Tulane Medical School and others; putting a patient to bed without any other treatment will often result in an increase in fluid output.

Harry Gold has very recently published a new treatment which is not only effective, but which permits ready measurement of the patient. In an address given before the New York Academy of Medicine, Jan. 10th, he stated that as a guide to treatment, the fluid sheets of intake and output should be abandoned, and that the patient may not clinically improve even under correct treatment. He has the patient weighed daily and feels that the body weight is more important as a measure of progress and prognosis than any other single standard. If the patient's body weight decreases every day, treatment is effective. If it does not, treatment should be increased, or altered.

Essentials of treatment is that dehydration is obtained, by the use of a low salt diet. the intravenous injection, or the intramuscular injection of a mercurial diuretic.

Mercuhydrin ½ cc. intramuscularly daily as long as the patient loses 2 or 3 pounds daily, increasing the dose to 1 or 2 cc. or even as high as 4 cc. Digitalis is given for auriculdar fibrillation, in doses of .2 mgs. daily after an initial dose of 1.2 mgs.

In severe cases, milk is given in quantities of 4 to 6 glasses daily with 2 quarts of water until decreased edema is evident.

The patients weight is taken daily until all edema and symptoms have disappeared. This is considered to be the patient's "dry weight". This is continued until there is a weight gain before injection, or a weight loss after injection. A recurrence is diagnosed by the weight gain of over 2 pounds.

Penicillin for Newborn's Eyes

Question:

May penicillin solution be used in place of the usual 1 percent silver nitrate solution in new born babies eyes? M.D.

Answer:

The use of penicillin 2,500 units per cc. in isotonic solution of sodium chloride is preferable to the use of silver nitrate, as it is more efficent and less irritating in the prevention of gonorrheal inflamation of the eyes in the newborn. For full details see H. C. Franklin in the *Journal of the American Medical Association*, Aug. 9. 1947.

Pains in Older Persons

Question:

I care for a number of older persons. They often complain of pains in the joints, legs or calves and tongue. Their general physical examinations are usually negative, with the exception of a mild or moderate iron deficiency anemia. Such pains are not relieved by the usual analgesics.—M.D., Iowa.

Answer:

The physician tends to forget that "we are what we eat." Most older persons take a very poorly banalnced diet, usually deficient in vitamins, minerals and protein and heavily overindulging in carbohydrate (bread, potatoes, cake, pie). Oral or injectable vitamin therapy, plus minerals orally, often makes these patients feel better. Very useful are the capsules containing B complex plus iron plus calcium and vitamin D (Nutritive capsules of Parke Davis or Prenatal capsules of Lederle) which give a basic supply. In some persons, vitamin B is not well absorbed orally; in such patients, inject B complex intravenously or intramuscularly in small doses at frequent intervals (as a water soluble vitamin, it is not well retained—as note the bright yellow color of the urine after oral or injection therapy). Older persons often improve after the weekly or two weekly injection of liver extract.

Prisoner of war studies show that joint and calf pains, roughened skin, tingling toes, bleeding gums, night blindness and painful tongue are due to nutritional deficiency (A.A. Goldbloom et al in *American Journal of Digestive Diseases*, 15:109 (April) 1948.

Treatment of Intussusception

Question: What is the safer treatment for intussusception, surgical reduction or reduction by means of barium enema? In a recent case, the surgeon insisted that open operation with reduction was safer but the radiologist stated, and showed, that it could be easily reduced with aid of the enema? Which is the best method?—M.D., Mississippi.

Answer: Roentgenologists have repeatedly reduced intussusceptions safely. If undertaken carefully, without sudden increases in hydrostatic pressure, the procedure is proven and not dangerous.

Ravitch and McCune recently demonstrated, in experimentally produced intussusceptions, that; (1) Hydrostatic pressure from an enema at a height of 3 feet for a period of 5 minutes, repeated when necessary, reduced 15 cm. intussusceptions which were fixed so as not to reduce spontaneously. (2) Prolonged delay in reduction, i.e. over 38 hours are usually not reducible with the enema. (3) Necrosis occurs in the returning limb of the intussusceptium. (4) In no case did rupture of the bowel occur. (5) In no case was a gangrenous loop of bowel reduced and (6) cultures taken from the serosal surface of an intussusception containing living bowel frequently showed pathogenic bacteria, an explanation for the fever, distention, abdominal abscesses, wound infections and postoperative adhesions with intestinal obstruction, which may complicate operative or occasionally non-operative reduction in the human being. (RAVITCH, MARK and MCCUNE, ROBERT: *Bulletin of Johns Hopkins Hospital*, 82:550 (May) 1948.)

Rectal Discomfort During Menstruation

Question:

I have a patient of 24 who complains of rectal discomfort at the time of menstruation. Examination shows a small, firm, rounded area behind the cervix which feels as though it is between the vagina and the rectum. What type of tissue may this be and what is the suggested treatment? — M. D., Joplin, Missouri.

Answer:

This small nodule is probably an adenomyoma of the recto-vaginal septum. This being composed of endometrial tissue will enlarge at each menstruation. It should be removed promptly.

Asthma in Older Persons

Question:

I have a person of 60 who has recurrent bronchial asthma. What can be done for him besides symptomatic treatment? —M. D., Des Moines, Iowa.

Answer:.

It was formerly felt that asthma in older persons was usually fixed, due to infection or to intrinsic causes that could not be discovered. With better study of patients, it is found that bronchial asthma occurring after the age of 55 years, is usually due, with about equal frequency, to food, and inhalant allergy—rarely to drug allergy, and very rarely to bacterial allergy.

The simplest starting point is to place the patients on Rowe's, cereal free, elimination diet. (A. H. Rowe's "Elimination Diets and the Patient's Allergy", 2nd Edition, Lea and Febiger, Philadelphia, Pa. - 1944).

Clinical food allergy rarely can be demonstrated by skin testing. The treatment of inhalant allergy requires strict environmental control when indicated, and desensitization with inhalants which cannot be excluded.

Sedatives of all types are contra-indicated in the treatment of asthma. Antibiotics are required when a secondary bacterial infection is present.

Symptomatic control involves the subcutaneous injection of adrenalin 1 to 1000, and doses ½ of cc. every 2 hours. If ineffective, amonophilline is given by vein in 5 to 7½ grain doses every 8 hours. Intravenous 5 per cent glucose in saline is given when dehydration is present.

For a recent review see A. H. Rowe "Bronchial Asthma in Patients Over Age 55 Years" in *Annals of Allergy*, November-December, 1947, page 509.

Treatment of Urticaria (Hives)

Question:

I have a patient, a girl of 22, who has urticaria repeatedly. Is this related to infected tonsils? What other treatment is indicated?—M.D., Nova Scotia.

Answer:

If the tonsils are definitely infected, or there is a clear-cut history of recurrent tonsillitis with fever, the tonsils should be removed.

Urticaria may be due to: 1. Food allergy; 2. bacterial allergy; 3. physical allergy; 4. serum reaction or 5. constitutional reaction to antigen for testing or treatment (Alexander Sterling).

Foci of infection should be removed. All drugs and medications including aspirin, sulfonamides, penicillin, laxatives and so on should be forbidden. Heat and cold cause hives in some susceptible persons.

Treatment:

The withdrawl of 10 cc. of the patient's blood and injection intramuscularly is an old procedure that relieves some patients after other methods have failed. If food allergy is suspected, a laxative should be given and saline solution enema, followed by a starvation diet, and baths with soda bicarbonate, starch or bran.

Benadryl is very effective: Usually 50 mg. is given three times daily; Pyribenzamine in similar doses may be tried.

Injections of 2 to 4 minims of epinenphrine with 2 to 4 minims of pituitary extract every 3 hours may be used. Intravenous calcium gluconate (10 cc. of 10 percent solution) may be given three times in 24 hours.

Paroxysmal Tachycardia

This Dept. (July 1948) suggested the use of ipecac as an emetic in the treatment of paroxysmal tachycardia. To get away from the side effect and discomfort of vomiting, I use 1cc. of prostigmine methyl sulfate sol. 1:2000 *(Roche)* and have had amazing results. I gladly pass this on as these conditions are frequently difficult, and this works!—Dr. Carter W. Luter, Butler, Mo.

Thumbnail Therapeutics

Fluids and Blood Substitutes for Burns

In the stage of shock, the first 24 or 48 hours, plasma and sodium chloride solution are needed in large amounts in extensive burns. In the second stage, extending for about ten days from the end of shock, the administration of sodium ions must be definitely restricted since, if salt solution is administered liberally, salt retention will occur and edema will follow. Plasma or whole blood is preferable during this period. In the third, or reparative stage, which may last for a long time, increased need for nutritive materials demands high protein and vitamin intake, supplemental whole blood, liver and iron to promote healing.—*Naval Med. Bull.*, 48, 99, Jan.-Feb. 1948.

Sulfonamide Sensitivity

Toxicity of the sulfonamides increases with the size of the dose. Sulfapyridine is reactive in 30% of cases, sulfathiazole in 12%, and sulfadiazine in 8%. The effects are directly toxic, mechanical, or allergic, and are usually slight but may be serious. Severe anemia or leukopenia, optic and peripheral neuritis, psychoses, and diffuse cerebral and cerebellar lesions renal damage, focal necrosis of the kidney, injury to the liver, colon or vascular systems may be produced. Many symptoms disappear on stopping therapy. Agranulocytosis is combatted with penicillin, pyridoxine, and folic acid. Anemia is treated by whole blood transfusions. During the treatment, fluid intake should be ample and the diet alkaline.—JOHN H. TALBOTT, M.D., Univ. of Buffalo Med. School, Buffalo, N. Y., in *N. Y. State Jrnl. of Med.* 48:280-286, 1948.

Penicillin for Otitis Media

The daily injection of 200,000 to 300,000 units of penicillin in oil and wax has cured the great majority cases of otitis media both acute and chronic. A total dose of 1,250,000 units is given.—I. GOTTLIEB, M.D., Sheffield, 5, England, in *British Med. Jrn.*, Jan. 17, 1948.

Stilbestrol for Miscarriage

The administration of stilbestrol in daily doses of 5 to 50 mg. will stop the bleeding or "spotting" of an early miscarriage.—R. S. MILLER, M.D. (Westbury, New York) in Medical Times, Sept. 1947.

Simple Treatment of the Menopause

A large number of women will respond satisfactorily to equal amounts of thyroid extract and phenobarbital, both for the physical and psychic aspects of the menopause. If estrogenic material is given, large amounts should be administered in the early portion of the treatment, gradually decreasing over a period of 6 to 12 months; the estrogens should be given cyclically, somewhat simulating normal ovarian rhythm; sedatives should usually be added.— WILLIS BROWN, M.D. (University Hospital, Iowa City, Iowa) in *J. Iowa S. M. S.*, May 1948.

Tridione

No patients with blood dyscrasia should receive this drug and in all cases other anticonvulsants should be tried first. Complete blood counts are made monthly and during menstruation and all unusual symptoms are reported to the physician without delay.—JOHN H. TALBOTT, M.D., Univ. of Buffalo, Med. School, in *N. Y. State Jrnl. of Med.*, 48:280-286. 1948.

Urinary Tract Infections

For routine use in urinary tract infections, mandelic acid and sulphonamide compound are the drugs of choice. Penicillin is an adjunct to treatment. Streptomycin produces spectacular results in some cases of resistant urinary infections, but cannot be used routinely. In all cases, obstruction, tumor, stone, or chronic inflammatory changes in the urinary tract must be diagnosed first.—EVERETT M. COOK, M.D., in *J.A.M.A.* March 1, 1947.

Broken Hypodermic Needle

The broken hypodermic needle can give great difficulty when lost in fleshy regions such as the buttock, and the search for them should not be undertaken lightly. If on the spot when the needle is broken, insert another needle at the same site, to act as a fingerpost and to assist later in the localization by x-ray. — J. G. BONNIN, F.R.C.S. in *Medical World* (Eng.), Nov. 21, 1947. (New needles practically never break. Rusty needles should be discarded before use. Needles should not be sterilized without a stylet being in the lumen of each needle. Longer needles, and this is especially true of those for lumbar puncture, deep intramuscular injections, nerve blocks and so on, should be tested by bending to see if they are flexible, before use. A "jittery" or nervous patient should be restrained or given a sedative before an injection of any consequence is given, to avoid sudden movement and breakage.—Ed.)

Thiouracil Effects

The most serious effect of thiouracil is agranulocytosis which is likely to occur in the second month of administration and is fatal in 30% of cases. Headache, diarrhea, purpura, and other symptoms may develop but subside on omission of the drug. Blood counts should be made weekly or more often during the second and third months and at least once a month at other times. Therapy is stopped at the first indication of leukopenia and penicillin given for at least a week. Propyl and methyl thiouracil appear to be less toxic but have not been thoroughly assayed.—JOHN H. TALBOTT, Univ. of Buffalo Med. School, in *N. Y. State Jrnl. of Med.* 48: 280-286, 1948.

Toxic Reactions to Streptomycin

One-fifth of all persons cannot take streptomycin without toxic symptoms. If the dose is increased to 4 gm. or more, 60% of persons will have toxic symptoms. Other effective agents should be substituted if possible. Tinnitus appears early, vertigo later. Several weeks of treatment will impair the vestibular function. If a rash occurs, medication is stopped, then resumed in small, slowly increased doses.—JOHN H. TALBOTT, M.D. Unv. of Buffalo Med. School, Buffalo, N. Y., in *N. Y. State Jrnl of Med., 48:280-286, 1948.*

Caffeine Sodium Benzoate for Acute Alcoholism

The intravenous injection of 1 Gm. (15 gr.) of caffeine with sodium benzoate to patients with acute alcoholism is recommended by F. F. Adler, M.D. (*J.A.M.A.*, 130, 530, 1946). Comatose patients are aroused and violently excited patients are quieted within 45 minutes due to the general stimulation of the central nervous system and the inhibitory centers.

Treatment of Pruritis Ani by Local Application

The moist perianal skin found in many patients with pruritus ani is probably due to leakage of material from the anal canal. This drainage material possesses enzymatic properties similar to trypsin, such proteolytically active material may cause skin irritation and intense itching. Local application of a paste made from aluminum hydroxide gel (aluminum hydroxide gel evaporated to the desired consistency, or thickened by the incorporation of kaolin) brings prompt and sustained relief to the majority of patients with "moist" pruritis ani, but is not generally effective in the "dry" type. FRIEDMAN, HASKALL and SNAPE, *J. Digestive Diseases*, 15, 57-60, Feb. 1948.

Curare for Tetanus

The use of curare in the treatment of tetanus even in heroic doses in the severe case, is justified.—A. R. MCINTYRE, M.D., in "Curare" (University of Chicago Press).

Diagnostic Pointers

Pain, Vomiting and Bloody Stools

Pain, vomiting and bloody stools when occuring in an infant or child signify an acute intussusception. These symptoms are found in ¾ of patients. In ¼ of such patients, there may be only one or two of these symptoms. Pain may never be present. A mass is palpable either abdominally or rectally in 80 percent of patients. X-ray is of aid in the diagnosis, either with use of a simple film of the abdomen ("scout" film) or after barium solution is injected into the rectum. The longer the symptoms are allowed to persist the higher the mortality rate will be, regardless of the location of the intussusception.—HARRY OBERHELMAN, M.D. (Loyola University Medical School, Chicago) in *Surg. Clin. N. Am.*, Feb. 1947.

Asthma Versus Thymus in Infants

Asthma is not a rare cause of wheezing respiration in infants. It is often due to milk allergy and may be relieved by eliminating milk from the diet. F. D. NANCE, M.D. (1133 Punchbowl Street, Honolulu) in *Hawaii M. J.*, July-Aug. 1947.

Unexplained Fever and Tachycardia

An unexplained elevation of pulse rate, temperature and respiratory rate should call for a careful clinical and x-ray study of the lungs for pulmonary embolus, and of the leg veins for thrombosis. This is true in post-operative, medical and obstetrical patients.—P. D. WHITE, M.D. (Massachusetts General Hospital, Boston) in *J.A.M.A.*, Aug. 23, 1947.

Intestinal Obstruction

The presence of symptoms of intestinal obstruction and a scar from a previous abdominal operation indicate the probability of obstruction due to adhesions.—WILLIAM HENDRICKS, M.D. (Cook County Hospital, Chicago) in *Surg. Clin. N. Am.*, Feb. 1947.

Fatigue and Malaise Without Signs

The patient who complains of being tired without physical signs, should have a differential blood smear to rule out infectious mononucleosis. This condition may persist for months, without fever appearing, and a diagnosis of neurosis be made.—M. W. WINTROBE, M.D. in "Clinical Hematology" (Lea & Febiger).

Cholecystography in Diagnosing Small Calculi

Cholecystograms made in the usual prone position often fail to reveal small stones or tumors when the gallbladder fills completely with the dye. The density of the vesicular shadow may totally obscure small cholesterin calculi or small intravesicular tumors. Flouroscopic and instantaneous serial roentgenograms with the patient in the standing position permit localization of the vesicular shadow in relation to surrounding structures, manipulation or compression of the gallbladder region and obtain the clearest view. In the standing position, concentrated bile and iodine is heavier than cholesterol concretions which consequently are suspended and produce a clear, translucent band that is very easily interpreted.—A. J. BURLANDO, *Postgrad. Med.*, 3, 114, Feb. 1948.

Petechiae in Children

Petechiae are commonly seen in children. Streptococcic toxin are probably responsible for many petechiae which appear to occur spontaneously. Careful history reveals that they appear with, or immediately after respiratory infections (Colds, tonsillitis, bronchitis) and joint and muscle pains. Petechiae occur at an earlier age and in greater numbers in rheumatic as compared with nonrheumatic children. There is a seasonal variation with a tendency towards greater number of petechiae in the spring and a decrease in the fall. They are seen also in the following acute and chronic infections: Acute infections; meningitis, Rocky Mountain spotted fever, typhus fever, severe scarlet fever, pneumonia, septicemia, scurvy, allergy, and virus diseases; Chronic infections: bacterial endocarditis, purpura and leukemia. Petechiae contain the causative agent in meningococcal and gonococcal septicemia. They may occur during the menses.—E. E. Brown, *Journ. Pediat.*, 32, 55-62, January 1948.

Patients Past 40

When a person older than 40 years is examined by a physician, the two most important disease conditions to consider are cancer and arteriosclerosis. C. C. Sturgis, M.D. in *Hawaii M. J.*, July-Aug. 1947.

Pain and Swelling of Leg

A history of mild pain in the leg, with a slight swelling, should alert the physician to the possibility of thrombosis of the deep veins of the leg. A considerable number of such thromboses occur without obvious cause in apparently well individuals who are engaged in their normal pursuits.—Louis Kaplan, M.D. (Surgical Service, Hospital of University of Pennsylvania, Philadelphia) in *Amer. Practitioner*, Aug. 1947.

Recurrence of Otitis Media

A recurrence of otitis media with purulent discharge from the ear may be due to an acute allergic manifestation which rekindles old middle ear suppuration. Allergy may be the sole cause.—French K. Hansel, M.D.

Unexplained Congestive Heart Failure

The patient who develops the symptoms of congestive cardiac failure, which rapidly progress, with or without pain, may have developed a coronary thrombosis and myocardial infarction.—C. C Sturgis, M.D. (University of Michigan Medical School, Ann Arbor, Mich.; in *Hawaii M. J.*, July-Aug. 1947.

Jaundice After Cholecystectomy

Given a patient with a history of a previous cholecystectomy, recurrent or persistent attacks of jaundice or cholangitis, should lead one to consider the diagnosis of stricture of the common bile duct.—Charles E. Rea, M.D. in *Minn. Med.*, July 1947. (The same symptoms occur when a common duct stone has been overlooked.—Ed.)

Pulmonary Embolism

A simultaneous rise in temperature, pulse rate and respiratory rate may be the first sign of pulmonary embolus, hours before any other subjective symptom or sign occurs. *The tachycardia is out of proportion to the degree of fever.*

Pain in the chest occurs in one-half of patients but is not an early symptom. Dyspnea occurs in one-third and hemoptysis in less than one-fifth of patients with pulmonary embolism. Physical signs in the chest are rare; pleural friction rub is heard in ten percent.

Both common femoral veins should be ligated to prevent further emboli from getting into the circulation. The ligation should be distal to the sapheno-femoral junction and proximal to the profunda femoris.—P. D. White, M.D. (Massachusetts General Hospital, Boston) in *J.A.M.A.*, Aug. 23, 1947.

Glaucoma Due to Disturbed Personality

More than 2/3 of patients with glaucoma show severe deviation from normal personality. In many instances, the behavior may border on the psychotic, with tendencies toward depression and hysteria, paranoia and schizophrenia.—H. L. Hibbeler, M.S. W. in *Am. J. Ophthalmol.*, Feb. 1947.

New Books

The Practice of Group Therapy

By S. R. Slavson, Editor.—International Universities Press. 1947. $5.00.

Group therapy not only permits a number of individuals to be treated at once but also permits inter-group adjustments and experiences. This is an interesting guide to actual therapy with allergic, psychotic, psychoneurotic, speech difficulty and other groups.

Congenital Malformations of the Heart

By Helen B. Taussig, M.D. Associate Professor of Pediatrics, Johns Hopkins University School of Medicine, Commonwealth Fund, 1947. $10.00.

Here is the foundation study of congenital heart disease which forms the basis for present day surgical relief of certain lesions. Case histories are given in full, together with illustrations and diagrams of the circulation.

Diseases of the Adrenals

By Louis J. Soffer, M.D. Adjunct attending Physician, The Mount Sinai Hospital, New York City. Lea and Febiger, 1946. Price $5.50.

The author has collected present day information concerning the function and diseases of the adrenals, together with details of chemical and mechanical technics involved.

Scoliosis

By Beatrice Woodcock, 1948. Stanford University Press. $2.00. A critical study of scoliosis and how it may be corrected, wholly or in part, by derotatory exercises, both active and passive.

The author appears to advocate the shifting of handedness in children with a right dorsal curve. This is a very major change to recommend in an adolescent patient and should be undertaken only after very careful consideration of the entire patient and not based solely on the geography of the patient's spine. The disturbances in personality that can follow such a shift are not to be taken lightly.

The Clinical Application for Psychological Tests

By Roy Schafer, M. A., International Universities Press. Price $6.75.

This book describes a method of applying a series of psychological tests, each one making a contribution to the delineation of personality features, and to show the subjects way of thinking. Psychologists who are called upon for diagnostic evaluation of tests results will find this book very useful.

Psychiatry for the Pediatrician

By Hale F. Shirley, M.D., Assoc. Professor of Pediatrics and Psychiatry, Executive Director of the Child Psychiatry Unit, Stanford Univ. School of Medicine. Published by The Commonwealth Fund. Price $4.50.

This is an excellent book for any physician to read and study, as well as one that every intelligent layman with children should be interested in reading. The author of this volume is an experienced teacher and practicing pediatrician and one who is well qualified to discuss the basic elements of child psychiatry with authority and insight.

Physical, mental and emotional disturbances are discussed and illustrated with case histories. The physician-parent and physician-child relationship is also intelligently discussed. This author suggests how to relieve worried parents of sick children so as to create a better atmosphere at home for the child.

This book is to be recommended to every medical student, pediatrician and general practitioner who lacks the basic training in child psychiatry. We believe that much will be gained.

Private Enterprise or Government in Medicine

By Louis H. Bauer, A.B., M.D., F.A.C.P. Published by the Charles C. Thomas Company. Prices $5.00.

The volume was written by a man well qualified to present an authoritative book on the topic which is of utmost importance to everyone today—government controlled medicine. Dr. Bauer has studied the medical care systems in the United States and other countries for a long time.

If you would like to familiarize yourself with the Wagner-Murray Dingell bill, The Hill-Burton Bill, and the Taft-Smith-Ball-Donnell Bill, read this book, by all means.

This book is well written in plain and easy to understand English and analyzes many important questions which are in the minds of physicians, dentists, and surgeons in the United States today.

Correlative Neuroanatomy

By J. J. McDonald, M.D., J. G. Chusid, M.D., J. Lange, M.D. Published by University Medical Publishers. Price $3.00.

This is a very excellent manual for the student of anatomy, neuroanatomy, neuro-diagnosis and neurology. The book is made up of 3 parts; the first dealing with the peripheral nerves, the second with neurodiagnosis, and the third section with disorders of the central nervous system. All major nerves are well illustrated and described. In the appendix, there is a complete list of neurological signs and syndromes and an outline of the neurological examination. The book can be highly recommended.

Modern Clinical Psychiatry

By Arthur P. Noyes, Supt., Norristown State Hospital, Norristown Penn. Published by W. B. Saunders Company, Price $6.00.

This is an excellent textbook written more or less for the student. Dr. Noyes has been lecturing for some time to senior students and at their suggestion has compiled his lectures and written them up in conventional book form.

Dr. Noyes has tried to show the more important ways in which anatomy, physiology, and chemistry produce changes in the organism and contribute to disturbances in personality integration.

This is quite a complete study of mental diseases and the author has a very nice, easy to understand style of writing. Every student of psychiatry would do well to read this volume and keep it in his library for reference.

Bright's Disease

By Henry A. Christian, A.M., M.D., LL.D., Sc.D. (Hon.), M.A.C.P., Hon. F.R.C.P. (Can.), D.S.M. (Am. Med. Assoc.) Hersey Prof. of the Theory and Practice of Physic, Emeritus, Harvard University. Published by the Oxford University Press. Price $9.00.

In this book, the author has presented his concept of Bright's disease. There is much detailed date of illustrative cases contained herein, the purpose being that the reading physician may compare the clinical and laboratory findings of his own patients with those described, from the onset to recovery or death, and the latter with post-mortem findings. The study is thorough and the book well written. This book can be recommended to those who have not familiarized themselves with this disease and have had little experience with it. Both the medical student and the practicing physician could gain much knowledge of this disease by reading Dr. Christian's excellent book.

Up from the Ape

By Earnest Albert Hooton, Professor of Anthropology, Harvard University; Curator of Somatology, Peabody Museum of Harvard University. Published by The Macmillan Company. Price $5.00.

This is the second edition to this work; the first being published some 15 years ago. The author has made a complete new book of this work and has added a lot to it which brings it right up-to-date. It is a very complete, authoritative volume on man's evolution. The writer has a very free and easy style, and his phraseology is so that anyone reading the book could not fail to be interested and to gain much knowledge.

There are many good photomicrographs of human hair and drawings that illustrate anthropometric technique, illustrations of racial types, et cetera.

This book will make very good reading for the physician, the student, and the educated layman.

The Selected Writings of Benjamin Rush

Edited by Dagobert D. Runes. Published by the Philosophical Library, Price $5.00.

For those who do not know, Benjamin Rush was one of the spiritual fathers of the American Revolution. He was a physician and a naturalist who gave most of his free time in working toward a democratic and free America. His writings collected in this volume, make very interesting and educational reading.

Health Teaching for Schools

By Ruth E. Grout, M.P.H., Ph.D., Published by W. B. Saunders Company. Price $4.00.

This book was written in particular for teachers and health workers who have contact with schools. It provides the teacher with up-to-date information on the health needs of the child. It offers definite materials to aid the teacher in planning and carrying out an effective health teaching program. And, it is written so that the teacher may read the entire book or turn to any one of the specific chapters which may best assist her in whatever her current problem may be.

What Is Psychoanalysis?

By Ernest Jones, M.D., Published by the International Universities Press, Price $2.00.

The author of this book has pressed a good deal of information into a very compact little volume. He answers the question "What is psychoanalysis?", gives a short history of psychoanalysis, describes the content of psychoanalysis, and the applications of psychoanalysis. While this book is not written in the detailed, heavy style that most books of this type are, it is very interesting, well written in a style anyone can understand, and can be recommended for student and general practitioner reading. For anyone specializing in this field, it would no doubt be a repetition of material already found in some of the more voluminous books on this subject.

Essays on Historical Medicine

By Bernard J. Ficarra, A.B., Sc.B., M.D., Professor of Research Biology in charge of Experimental Physiology, St. Francis' College, Brooklyn, New York. Published by Froben Press, Inc. Price $5.00.

A very compact, interesting little volume of some 200 pages dealing with the history of medicine and the men who have made medical history. There are several interesting illustrations and photographs contained herein also. It is an accepted fact, that all physicians should know a certain amount about the history of medicine as there are many lessons to be learned from it. This book should act as a stimulator to those who have delved deeply into historical medicine as well as those who have only just skimmed the history of their profession lightly.

America's Needs and Resources

By J. Frederic Dewhurst and Associates. Published by The Twentieth Century Fund. Price $5.00.

This book is a survey which includes estimates for 1950 and 1960. The survey indicates that if we can continue our past rate of growth through the next decade, we can provide our people with still more goods and services than at the wartime peak, with less hours of work. There are many explanatory graphs and tables to help the reader understand. The book takes everything into consideration; housing, clothing, food household operation, consumer transportation, *medical care*, recreation, government expeditures, et cetera. The book is very thorough, and since most people are interested in obtaining information of this type, much knowledge can be gained from reading this book which is written in a plain and easy to understand manner.